

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3907AGZ	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/17/2009
NAME OF PROVIDER OR SUPPLIER WICKER BASKET		STREET ADDRESS, CITY, STATE, ZIP CODE 3020 BEAUFORT CT N LAS VEGAS, NV 89032		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	<p>Initial Comments</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.</p> <p>This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 6/17/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility received a grade of D.</p> <p>The facility is licensed for 10 Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. The census at the time of the survey was eight. Eight resident files were reviewed and four employee files were reviewed. One discharged resident file was reviewed.</p> <p>The following deficiencies were identified:</p>	Y 000		
Y 070 SS=E	<p>449.196(1)(f) Qualifications of Caregiver-8 hours training</p> <p>NAC 449.196 1. A caregiver of a residential facility must: (f) Receive annually not less than 8 hours of training related to providing for the needs of the residents of a residential facility.</p> <p>This Regulation is not met as evidenced by: Based on record review on 6/17/09, the facility failed to ensure that 1 of 3 caregivers received eight hours of annual training (Employee #2).</p>	Y 070		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3907AGZ	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/17/2009
NAME OF PROVIDER OR SUPPLIER WICKER BASKET		STREET ADDRESS, CITY, STATE, ZIP CODE 3020 BEAUFORT CT N LAS VEGAS, NV 89032		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 070	Continued From page 1 Severity: 2 Scope: 2	Y 070		
Y 103 SS=F	449.200(1)(d) Personnel File - NAC 441A NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee. This Regulation is not met as evidenced by: Based on record review on 6/17/09, the facility failed to ensure 2 of 4 caregivers complied with NAC 441A.375 regarding tuberculosis testing for the protection of all residents. (Employee #1 was missing evidence of a positive tuberculosis test, a chest x-ray, and annual signs and symptoms as she stated she has tested positive in the past, and #4 was missing an annual tuberculosis test.) This was a repeat deficiency from the 9/11/08 State Licensure survey. Severity: 2 Scope: 3	Y 103		
Y 105 SS=F	449.200(1)(f) Personnel File - Background Check NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.176 to	Y 105		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3907AGZ	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2009
NAME OF PROVIDER OR SUPPLIER WICKER BASKET			STREET ADDRESS, CITY, STATE, ZIP CODE 3020 BEAUFORT CT N LAS VEGAS, NV 89032		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 105	Continued From page 2 449.185, inclusive. This Regulation is not met as evidenced by: Based on record review on 6/17/09, the facility failed to ensure 3 of 4 employees met the background check requirements. (Employee #1 did not have evidence of a FBI check, Employee #2 did not sign a criminal history statement and Employee #4 did not have a copy of fingerprints in the file) This was a repeat deficiency from the 9/11/08 State Licensure survey. Severity: 2 Scope: 3	Y 105			
Y 172 SS=B	449.209(2) Health and Sanitation-Outside garbage NAC 449.209 2. Containers used to store garbage outside of the facility must be kept reasonably clean and must be covered in such a manner that rodents are unable to get inside the containers. At least once each week, the containers must be emptied and the contents of the containers must be removed from the premises of the facility. This Regulation is not met as evidenced by: Based on observation on 6/17/09, the facility failed to cover 1 of 2 exterior trash cans. Severity: 1 Scope: 2	Y 172			
Y 179 SS=D	449.209(6) Health and Sanitation-Screens	Y 179			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3907AGZ	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/17/2009
NAME OF PROVIDER OR SUPPLIER WICKER BASKET		STREET ADDRESS, CITY, STATE, ZIP CODE 3020 BEAUFORT CT N LAS VEGAS, NV 89032		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 179	Continued From page 3 NAC 449.209 6. All windows that are capable of being opened in the facility and all doors that are left open to provide ventilation for the facility must be screened to prevent the entry of insects. This Regulation is not met as evidenced by: Based on observation on 6/17/09, the facility failed to ensure there were screens on 1 of 7 bedroom windows. (Bedroom # 1) Severity: 2 Scope: 1	Y 179		
Y 353 SS=E	449.222(3) Bathrooms and Toilet Facilities NAC 449.222 3. The bottoms of tubs and showers must have surfaces that inhibit falling and slipping. Cabinets that are attached to the floor or grab bars must be adjacent to the tubs, toilets and showers. This Regulation is not met as evidenced by: Based on observation on 6/17/09, the facility failed to ensure there were grab bars adjacent to the toilet in 1 of 3 bathrooms. (Master bathroom in bedroom #4) Severity: 2 Scope: 2	Y 353		
Y 356 SS=F	449.222(6) Bathrooms and Toilet Facilities NAC 449.222 6. Bathroom doors that are equipped with locks must open with a single motion from the inside without the use of a key. If a key is required to open a lock from outside the bathroom, the key	Y 356		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3907AGZ	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2009
NAME OF PROVIDER OR SUPPLIER WICKER BASKET			STREET ADDRESS, CITY, STATE, ZIP CODE 3020 BEAUFORT CT N LAS VEGAS, NV 89032		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 356	Continued From page 4 must be readily available at all times. This Regulation is not met as evidenced by: Based on observation on 6/17/09, the facility failed to ensure 2 of 3 bathroom doors were equipped with single motion locks. (Master bathroom inside bedroom #4, and the bathroom across the hall from bedroom # 1 had double motion locks.) Severity: 2 Scope: 3	Y 356			
Y 434 SS=D	449.229(3) Emergency Drills NAC 449.229 3. A drill for evacuation must be performed monthly on an irregular schedule, and a written record of each drill must be kept on file at the facility for not less than 12 months after the drill. This Regulation is not met as evidenced by: Based on record review on 6/17/09, the facility did not ensure that monthly evacuation drills were conducted on an irregular schedule for 1 of 12 months (May of 2009). Severity: 2 Scope: 1	Y 434			
Y 444 SS=D	449.229(9) Smoke Detectors NAC 449.229 9. Smoke detectors must be maintained in proper operating conditions at all times and must be tested monthly. The results of the tests pursuant	Y 444			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3907AGZ	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2009
NAME OF PROVIDER OR SUPPLIER WICKER BASKET			STREET ADDRESS, CITY, STATE, ZIP CODE 3020 BEAUFORT CT N LAS VEGAS, NV 89032		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 444	Continued From page 5 to this subsection must be recorded and maintained at the facility. This Regulation is not met as evidenced by: Based on record review on 6/17/09, the facility did not ensure smoke detectors were tested 1 out of the past 12 months (May of 2009). Severity: 2 Scope: 1	Y 444			
Y 530 SS=F	449.260(1)(e) Activities for Residents NAC 449.260 (e) Provide for the residents at least 10 hours each week of scheduled activities that are suited to their interests and capacities. This Regulation is not met as evidenced by: Based on interview, observation and activity calendar review on 6/17/09, the facility failed to provide at least 10 hours of appropriate activities for 8 of 8 residents with dementia (Resident #1, #2, #3, #4, #5, #6, #7 and #8). No activities with residents were conducted during the survey, residents reported there were no other activities offered other than watching TV and the caregiver could produce examples of items used for activities listed on the activity calendar. Severity: 2 Scope: 3	Y 530			
Y 923 SS=F	449.2748(3)(b) Medication Container	Y 923			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3907AGZ	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/17/2009
NAME OF PROVIDER OR SUPPLIER WICKER BASKET		STREET ADDRESS, CITY, STATE, ZIP CODE 3020 BEAUFORT CT N LAS VEGAS, NV 89032		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 923	Continued From page 6 NAC 449.2748 3. Medication, including, without limitation, any over-the-counter medication or dietary supplement, must be: (b) Kept in its original container until it is administered. This Regulation is not met as evidenced by: Based on observation and interview on 6/17/09, the facility failed to keep medications belonging to 8 of 8 residents in their original container. Evening medications for Residents #1, #2, #3, #4, #5, #6, #7 and #8 were stored in the locked kitchen cabinet in small plastic cups labeled with the resident's names. Severity: 2 Scope: 3	Y 923		
Y 936 SS=F	449.2749(1)(e) Resident file NAC 449.2749 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto.	Y 936		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3907AGZ	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2009
NAME OF PROVIDER OR SUPPLIER WICKER BASKET			STREET ADDRESS, CITY, STATE, ZIP CODE 3020 BEAUFORT CT N LAS VEGAS, NV 89032		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 936	Continued From page 7 This Regulation is not met as evidenced by: Based on record review on 6/17/09, the facility failed to ensure 3 of 8 residents complied with NAC 441A.380 regarding tuberculosis testing (Resident #3, #5 and #6) which affected all residents. Severity: 2 Scope: 3	Y 936			
Y 991 SS=E	449.2756(1)(b) Alzheimer's Fac door alarm NAC 449.2756 1. The administrator of a residential facility which provides care to persons with Alzheimer's disease shall ensure that: (b) Operational alarms, buzzers, horns or other audible devices which are activated when a door is opened are installed on all doors that may be used to exit the facility. This Regulation is not met as evidenced by: Based on observation on 6/17/09, the facility failed to ensure 1 of 3 exits had an operational alarm, buzzer, horn or other audible device (Sliding glass door leading out of bedroom #4 to the backyard). Severity: 2 Scope: 2	Y 991			
Y 992 SS=F	449.2756(1)(c) Alzheimer's Fac awake staff NAC 449.2756 1. The administrator of a residential facility which	Y 992			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3907AGZ	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2009
NAME OF PROVIDER OR SUPPLIER WICKER BASKET			STREET ADDRESS, CITY, STATE, ZIP CODE 3020 BEAUFORT CT N LAS VEGAS, NV 89032		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 992	Continued From page 8 provides care to persons with Alzheimer's disease shall ensure that: (c) At least one member of the staff is awake and on duty at the facility at all times. This Regulation is not met as evidenced by: Based on interview with staff on 6/17/09, the facility failed to ensure at least one member of the staff was awake and on duty in the facility at all times. (Staff stated the caregivers sleep at night and get up two and three times to check on residents) Severity: 2 Scope: 3	Y 992			
Y 994 SS=F	449.2756(1)(e) Alzheimer's fac knives NAC 449.2756 1. The administrator of a residential facility which provides care to persons with Alzheimer's disease shall ensure that: (e) Knives, matches, firearms, tools and other items that could constitute a danger to the residents of the facility are inaccessible to the residents. This Regulation is not met as evidenced by: Based on observation on 6/17/09, the facility failed to ensure dangerous items were inaccessible to the residents. A razor was found under the sink in the bathroom in bedroom #4. A dresser in bedroom #4 contained hair scissors, nail clippers and a pair of pliers.	Y 994			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3907AGZ	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/17/2009
NAME OF PROVIDER OR SUPPLIER WICKER BASKET		STREET ADDRESS, CITY, STATE, ZIP CODE 3020 BEAUFORT CT N LAS VEGAS, NV 89032		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 994	Continued From page 9 This was a repeat deficiency from the 9/11/08 State Licensure survey. Severity: 2 Scope: 3	Y 994		
Y 999 SS=F	449.2754(1)(g) Alzheimer's Facility NAC 449.2756 1. The administrator of a residential facility which provides care to persons with Alzheimer's disease shall ensure that: (g) All toxic substances are not accessible to the residents of the facility. This Regulation is not met as evidenced by: Based on observation on 6/17/09, the facility failed to ensure all toxic substances were not accessible to the residents of the facility. (A shed in the back yard was not secured and contained insecticide) Severity: 2 Scope: 3	Y 999		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.